MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09112

CERTIFICATE OF DEATH

9113 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 2days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen.
d. STREET ADDRESS 44 Monroe
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Alfred Last Ames

4. DATE OF DEATH Month 8 Day 8 Year 1958

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb. 26, 1934
9. AGE (In years last birthday) 24 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ballistics
10b. KIND OF BUSINESS OR INDUSTRY A.P.G.
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel N. Ames.
14. MOTHER'S MAIDEN NAME Elsie Willis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-30-5729
17. INFORMANT Mrs Victoria Ames - Aberdeen, Md Address 44 monroe St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
415x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Acute Rheumatic Myocarditis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gastroduodenitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 29, 1958, to Aug. 8, 1958, that I last saw the deceased alive on Aug 8, 1958, and that death occurred at 3:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 8/11/58
PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-11-58
22c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem.
22d. LOCATION (City, town, or county) Aberdeen (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE A. J. Bullock, Havre de Grace Md. ADDRESS
24a. REC'D BY REGISTRAR DATE AUG 13 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the M[illegible] or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9114

CERTIFICATE OF DEATH

09113
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 16½ hrs
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
d. STREET ADDRESS: 409 Juniata St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Austin Middle: Joshua Last: Bennett
4. DATE OF DEATH: Month: August Day: 4 Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APR. 21, 1897
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Contractor
10b. KIND OF BUSINESS OR INDUSTRY: self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bennett
14. MOTHER'S MAIDEN NAME: Elizabeth Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 147-09-2582
17. INFORMANT: Mrs. Blenda J. Bennett Address: Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
332 X
DUE TO (b): Arteriosclerosis cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/3/58 to 8/4/58 that I last saw the deceased alive on 8/4/58, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bonn L. Wadsworth M.D. ADDRESS (Street, city or town, state): 402 S. Union Ave DATE SIGNED: 8/4/58
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-7-1958
22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL
22d. LOCATION (City, town, or county) (State): HAVRE DE GRACE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell ADDRESS: HAVRE DE GRACE MD.
24a. REC'D BY REGISTRAR DATE: AUG 7 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Complete this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 233 9-18-58 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 09114

9115

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
d. STREET ADDRESS RT. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Everett Middle Oscar Last Broadfield.
4. DATE OF DEATH Month 8 Day 2 Year 1958
5. SEX Male
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/3/1883
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY General Store
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Everett Broadfield.
14. MOTHER'S MAIDEN NAME Lena Neidline.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Laura Broadfield (wife) Rt. #2 Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia - Acute
DUE TO (b) Membranous Entero Colitis
DUE TO (c) Chronic Myocarditis -
INTERVAL BETWEEN ONSET AND DEATH

046.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

490x Autopsy revealed: Acute amoebic dysentery; intestinal type

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3-26 19 58 to Aug 2 19 58 that I last saw the deceased alive on August 2 19 58, and that death occurred at 7:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. C. L. Lewis M.D. ADDRESS (Street, city or town, state) Havre de Grace Md DATE SIGNED 8-6-58
PHYSICIAN'S NAME (Type) A. L. Lewis Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/5/58
22c. NAME OF CEMETERY OR CREMATORY Angel Hill
22d. LOCATION (City, town, or county) (State) Havre de Grace, Md

23. FUNERAL DIRECTOR'S SIGNATURE Thomas Lee Dix ADDRESS Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE AUG 8 '58
24b. REGISTRAR'S SIGNATURE W. H. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9136 — 09115 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - STREET
c. LENGTH OF STAY IN 1b: 56 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X STREET
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First JOHN — Middle W. — Last BURKINS

4. DATE OF DEATH: Month AUG. — Day 12, — Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR. 13, 1902

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RURAL LETTER CARRIER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT.

11. BIRTHPLACE (State or foreign country): STREET, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES W. BURKINS

14. MOTHER'S MAIDEN NAME: MARGARET RIGDON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: MRS. HILDA A. BURKINS, STREET, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Atherosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ~~PRE~~ Myocardial infarction 1955

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 Nov, 19 57, to 12 Aug, 19 58, that I last saw the deceased alive on 10 Aug, 19 58, and that death occurred at 1 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos. A.E. Moseley M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 12 Aug 1958

PHYSICIAN'S NAME (Type): THOS. A.E. MOSELEY, JR — JARRETTSVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 8-15-58 — 22c. NAME OF CEMETERY OR CREMATORY: EMORY — 22d. LOCATION (City, town, or county) (State): STREET, HARFORD CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John H. Harkins, Delta, Pa.

24a. REC'D BY REGISTRAR — DATE: AUG 18 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9137 **CERTIFICATE OF DEATH** 09116

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS R. F. D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Georgiann Middle: Cannon Last:
4. DATE OF DEATH Month: 8 Day: 30 Year: 1958

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct. 2, 1870
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months: 10 Days: 28
IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harford County, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Joseph Collins
14. MOTHER'S MAIDEN NAME Sabina Gilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. none
17. INFORMANT Address: Mrs. Elva N. Johnson Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Hypertensive-Arteriosclerotic Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 10, 1956, to Aug. 30, 1958, that I last saw the deceased alive on Aug. 29, 1958, and that death occurred at 9:10 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 8/30/58

PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-3-58
22c. NAME OF CEMETERY OR CREMATORY Green Spring Cem.
22d. LOCATION (City, town, or county) Green Spring (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Otelia J. Bullock Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE SEP 3 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09117

CERTIFICATE OF DEATH

9116 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN 1b: 4 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

d. STREET ADDRESS: Edmund St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET (Maggie) Middle Lena Last COWSER

4. DATE OF DEATH: Month August Day 18 Year 1958

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 Mar. 1896

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? XXXXXXX Ned Harvy

14. MOTHER'S MAIDEN NAME: Nellie —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT Address: Fred Cowser-Husband- Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: One week (7 days)

DUE TO (b): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 5 19__ to Aug 17 19__ that I last saw the deceased alive on Aug 17 19 58, and that death occurred at 10:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew Weiss M.D. ADDRESS (Street, city or town, state): 17 N Phila. Blvd. Aberdeen Md. DATE SIGNED

PHYSICIAN'S NAME (Type): ANDRE WEISS 8/18/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/21/58

22c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cemetery

22d. LOCATION (City, town, or county) (State): St. Thomas, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Fanning ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subsequent pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09118

9138

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Bel Air

LENGTH OF STAY (in this place): 3 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Harford Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

STREET ADDRESS (If rural give location): /

3. NAME OF DECEASED (Type or Print): Carrie (First) Preston (Middle) Cunningham (Last)

4. DATE OF DEATH: August (Month) 22 (Day) 19 58 (Year)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	August 5, 1869	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob E. Bull

14. MOTHER'S MAIDEN NAME: Mary Sunderland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: /

17. INFORMANT & ADDRESS: Mrs. Mary L. Laird, 1106 Ashury Ave. Balto. 6, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Carcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH: 18 months

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B):

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Toxic goiter — 3 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 19 48, to March 22, 19 58, that I last saw the deceased alive on March 21, 19 58, and that death occurred at 12:20 P M, from the causes and on the date stated above.

SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city, town, state): Forest Hill, Maryland — DATE SIGNED: August 22, 1958

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 25, '58	Rock Spring Episcopal	Forest Hill, Maryland

24. REC'D BY REGISTRAR DATE: AUG 26 '58 — REGISTRAR'S SIGNATURE: C. [illegible] & Evans

25. FUNERAL DIRECTOR'S SIGNATURE: Joseph T. Foster — ADDRESS: Bel Air Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9117

CERTIFICATE OF DEATH

Reg. Dist. No. 09119

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 36 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d STREET ADDRESS: 7 MONROE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: FIELDS
4. DATE OF DEATH: Month: August — Day: 5 — Year: 1958

5. SEX: FEMALE
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-3-58
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: 12 — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Ambrose Fields
14. MOTHER'S MAIDEN NAME: MARION LOUISE BOOBY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Premature Birth
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-3 1958 to 8-5 1958 that I last saw the deceased alive on 8-4 1958 and that death occurred at 12:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town; state): [illegible]
DATE SIGNED: 8-5-58
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 8-5-58
22c NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL HOSPITAL
22d LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Harry R Tilley
ADDRESS: administration
24a. REC'D BY REGISTRAR DATE AUG 8 '58
24b REGISTRAR'S SIGNATURE: [signature]

2071428XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9118

CERTIFICATE OF DEATH

09120
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d STREET ADDRESS General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ARTHUR Middle Finkernagel Last
4. DATE OF DEATH Month August Day 20 Year 1958

5 SEX male
6. COLOR OR RACE white
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 20 April 1886
9. AGE (In years last birthday) 72 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXXXX
10b. KIND OF BUSINESS OR INDUSTRY Railroad, Brakeman (Ret.)
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME John Finkernagel
14 MOTHER'S MAIDEN NAME Annie Oals

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-12-0876
17 INFORMANT Frances Preston SISTER Address 423 Roberts Way, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema, Bronchopneumonia, Azotemia
491X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4, 1958, to 8-20, 1958, that I last saw the deceased alive on 8-20, 1958, and that death occurred at 12-50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Frank D. Hauber M.D. ADDRESS (Street, city or town, state) 608 So. Union Ave. Havre de Grace, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Frank D. Hauber M.D. 20 August 1958

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 8/23/58
22c. NAME OF CEMETERY OR CREMATORY Angel Hill
22d. LOCATION (City, town, or county) (State) Havre de Grace, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring ADDRESS Aberdeen, Md.
Tarring Funeral Home
24a. REC'D BY REGISTRAR DATE AUG 25 58
24b REGISTRAR'S SIGNATURE C. Wm. L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician or completely filled in by the funeral director. [illegible] for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within [illegible] other death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09121

9119

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hosp. (DOA)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: RD #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Charles — Middle: W. — Last: Glassman Sr.

4. DATE OF DEATH: Month: August — Day: 5 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 23 July 1888
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: State Rd. Comm.
11. BIRTHPLACE (State or foreign country): Churchville, Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Glassman
14. MOTHER'S MAIDEN NAME: Marie Whitne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.: 220-36-8622
17. INFORMANT: Charles W. Glassman Jr. Address: R.D. 1 Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Odema — INTERVAL BETWEEN ONSET AND DEATH: immediate
DUE TO (b): Arteriosclerotic H-V Disease — 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 1942 to Aug, 1958 that I last saw the deceased alive on Aug 3, 1958, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Ralph Horky, M.D. — ADDRESS (Street, city or town, state): Churchville — DATE SIGNED: Aug 5
PHYSICIAN'S NAME (Type): J. Ralph Horky

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/58
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d. LOCATION (City, town, or county) (State): Churchville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Fanning — ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: AUG 8 '58
24b. REGISTRAR'S SIGNATURE: W. Leech

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FOR STATE HEALTH DEPT.

M

01

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09122

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: — Last: Hall

4. DATE OF DEATH: Month: August — Day: 23 — Year: 19 58

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 6, 1902

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HR.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Wilkes Co. N. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Owen Hall

14. MOTHER'S MAIDEN NAME: Sarah Absher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 239-09-4539

17. INFORMANT: Mr. Clay Hall — Address: Street Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GSW Cerebrum
976X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with pistol

20c. TIME OF INJURY: Hour: 10 a. m. p. m. — Month, Day, Year: 8-23 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Street — (County): Harford — (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Bel Air, Md

DATE SIGNED: 8-23-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Aug 25, 1958

22c. NAME OF CEMETERY OR CREMATORY: Fairview

22d. LOCATION (City, town, or county): Surry Co. (State): N C

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey

ADDRESS: Darlington Md

24a. RECD BY REGISTRAR (Date): AUG 26 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Marks

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages [illegible] and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages [illegible] with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1 D

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 & 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09123

9140 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARDIFF
c. LENGTH OF STAY IN 1b: 58 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAIN ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CARDIFF
d. STREET ADDRESS: MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle WARREN — Last HARVEY

4. DATE OF DEATH: Month AUGUST — Day 26 — Year 19 58

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC 29 1899

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: MACHINES

11. BIRTHPLACE (State or foreign country): CARDIFF, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES ALEXANDER HARVEY

14. MOTHER'S MAIDEN NAME: ELIZABETH R. JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 008-07-8615

17. INFORMANT: HOWARD HARVEY — Address: (SAME)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
420.1
DUE TO (b): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour ___ a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug 26, 1958

EXAMINER'S NAME (Type): PHILIP W. HEUMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-29-58
22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE
22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John H. Hobbins, Delta, Pa.

24a. REC'D BY REGISTRAR — DATE: AUG 29 58

24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9120 — 09124 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 33 minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 1130 N Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sentman — Middle — Last Hill

4. DATE OF DEATH: Month Aug. — Day 22 — Year 1958

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/24/1894
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: Chesapeake Ironworks
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Scott Hill
14. MOTHER'S MAIDEN NAME: Anne Charlotte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Elizabeth Hill (wife) — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Angina
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1958, to August 22, 1958, that I last saw the deceased alive on August 22, 1958, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J. Simon, M.D. — ADDRESS (Street, city or town, state): Havre de Grace, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): EDWARD J. SIMON — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/25/58
22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin
22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Lee Sr. — ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: AUG 26 '58
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. It should be defaced for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 shown and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal. If in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9141 — 09125 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyde R.D.
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyde R.D.
d. STREET ADDRESS: Reckord
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Ruby — Last: Hooper
4. DATE OF DEATH: Month: August — Day: 17 — Year: 19 55

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 4 1891
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: County Roads
11. BIRTHPLACE (State or foreign country): Redkord, Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Columbus Hooper
14. MOTHER'S MAIDEN NAME: Mary Orem

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. 1
16. SOCIAL SECURITY NO.: 213-26-0426
17. INFORMANT: Clarence Hooper, Address: Reckord Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive C V disease
4437
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
Bel Air, Md. DATE SIGNED: 8-18-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 21, 1958
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
22d. LOCATION (City, town, or county) (State): Baltimore Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. McCann Jr.
ADDRESS: Abingdon Md.
24a. REC'D BY REGISTRAR DATE: AUG 22 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9142

CERTIFICATE OF DEATH

09126

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITEFORD
c. LENGTH OF STAY IN 1b: 86 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITEFORD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: BENJAMIN — Middle: HIRAM — Last: JONES

4. DATE OF DEATH: Month: AUG. — Day: 22, — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: NOV. 11, 1872

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN-

10b. KIND OF BUSINESS OR INDUSTRY: HIGHWAY DEPT.

11. BIRTHPLACE (State or foreign country): WHITEFORD, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HIRAM JONES

14. MOTHER'S MAIDEN NAME: SARA JANE NORRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 215-18-7229

17. INFORMANT: WARFIELD JONES, Address: WHITEFORD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Art. Scler. Cerebro-Vascular Disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1940, to Aug 22, 1958, that I last saw the deceased alive on Aug 21, 1958, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Josiah A Hunt M.D. — ADDRESS (Street, city or town, state): Delta Pa — DATE SIGNED: Aug 25 '58

PHYSICIAN'S NAME (Type): Josiah A. Hunt

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-25-'58

22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hoffman — ADDRESS: DELTA, PA.

24a. REC'D BY REGISTRAR — DATE: AUG 26 '58

24b. REGISTRAR'S SIGNATURE: Carling S. Kinsey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9121 — 09127 — Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
c. LENGTH OF STAY IN 1b: 36 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elsie — Middle: Mary — Last: Keilholtz
4. DATE OF DEATH: Month: Aug. — Day: 31 — Year: 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 8, 1898
9. AGE (In years last birthday): 60 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Rising Sun, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Harvey K. Garvin
14. MOTHER'S MAIDEN NAME: Mary Ewing
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Clyde Keilholtz — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	2 days
DUE TO (b)	Arteriosclerosis	5 yrs.
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/25, 1958 to 8/31, 1958, that I last saw the deceased alive on 8/31, 1958, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 9/1/58
PHYSICIAN'S NAME (Type): Neil Taylor Jr — Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 3, 1958
22c. NAME OF CEMETERY OR CREMATORY: Brookview Cem.
22d. LOCATION (City, town, or county): Rising Sun — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rising Sun, Md
24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kreuz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09128

CERTIFICATE OF DEATH

9143 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: Since birth
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, APG, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 125 Osborne Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SHEALA Middle: Last: LAY

4. DATE OF DEATH: Month: August Day: 8 Year: 1958

5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 August 1958
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months: Days: 1
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA
10b. KIND OF BUSINESS OR INDUSTRY: NA
11. BIRTHPLACE (State or foreign country): Aberdeen, Maryland
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CURTIS WAYNE LAY
14 MOTHER'S MAIDEN NAME: Elisabeth Seiberth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father — Address: 125 Osborne Road Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Distress — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
P 102.0
DUE TO (b): Possible aspiration after birth
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 August, 1958, to 8 August, 1958, that I last saw the deceased alive on 8 August, 1958, and that death occurred at 6:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John Z. Delp M.D.
ADDRESS (Street, city or town, state): USAH, APG, Md.
DATE SIGNED: 8 August 1958
PHYSICIAN'S NAME (Type): JOHN Z DELP CAPT MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 11th 1958
22c. NAME OF CEMETERY OR CREMATORY: Post Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Proving Ground, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Sabrung
ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: AUG 12 1958
24b. REGISTRAR'S SIGNATURE: Arthur A. Krauss

1222XV6

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09129

9144 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Rocks
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Woods near Rocks State Park

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks
d. STREET ADDRESS: RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle RALPH — Last LOGAN

4. DATE OF DEATH: Month August — Day 29 — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 6 1900

9. AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day

11. BIRTHPLACE (State or foreign country): Belair Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Logan

14. MOTHER'S MAIDEN NAME: Sarah Ann Terry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 220-07-8922

17. INFORMANT: Mrs Eugene Everett — Address: Rocks Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Undetermined.
795.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — Month, Day, Year — a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Willie V Lovitt M.D.
EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 8/30/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 2-58
22c. NAME OF CEMETERY OR CREMATORY: Friend-Ship
22d. LOCATION (City, town, or county) (State): Fallston Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Martin G Kurtz Jarrettsville Md

24a. REC'D BY REGISTRAR: DATE SEP 3 '58

24b. REGISTRAR'S SIGNATURE: Arthur L Thomas

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9145

09130 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWOOD (RURAL)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WINTERS RUN 1/4 MILE WEST State Rd #7

2. USUAL RESIDENCE (Where deceased lived. If inst tut on Residence before admission)
a. STATE: NORTH CAROLINA — b. COUNTY: Burke
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hickory
d. STREET ADDRESS: R+ #4
e. IS RES DE CE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERMAN — Middle PRESSLY — Last LYNN

4. DATE OF DEATH: Month AUGUST — Day 9 — Year 1958

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 5, 1929

9. AGE (In years last birthday): 29 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Fabric

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Lynn

14. MOTHER'S MAIDEN NAME: Martha Kiser,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO: 242-52-3324

17. INFORMANT: Hazel Willis Lynn, Address: Hickory, N.C.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN

DUE TO (b): DROWNING

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 11:45 a. m. — Month, Day, Year: AUG 9 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): STREAM

20f. (City or town): SANBIBER — (County): HARFORD, — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Herman M.D

EXAMINER'S NAME (Type): PHILIP W. HERMAN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: AUG 9, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Aug. 10 1958

22c. NAME OF CEMETERY OR CREMATORY: Kirksey Funeral Home

22d. LOCATION (City, town, or county): Morganton, Burke, (State): N.C.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. McComas Jr

ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR DATE: AUG 13 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9122

CERTIFICATE OF DEATH

09131

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 mos. 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 6752 Golabird Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address): Harford Memorial Hospital

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: A. — Last: Meyers

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1958

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 8, 1874

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): BALTIMORE, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES MEYERS

14. MOTHER'S MAIDEN NAME: WILHELMINIA SCHROEDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Elizabeth Stone (sister) Address: 1400 W. Lexington St. Baltimore

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 30 days

DUE TO (b): Arteriosclerotic Gangrene R. Leg — 2 1/2 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Advanced ASCVD disease c decubitus ulcers of the extremities and back — Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 18, 1958 to Aug 21, 1958 that I last saw the deceased alive on Aug 21, 1958, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. H. Sadowsky M.D. ADDRESS (Street, city or town, state): 600 S. Union Ave, Havre de Grace DATE SIGNED: 8/21/58

PHYSICIAN'S NAME (Type): W H SADOWSKY MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 25, 1958

22c. NAME OF CEMETERY OR CREMATORY: OAK LAWN

22d. LOCATION (City, town, or county) (State): BALTIMORE Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: William Cook Son — ADDRESS: 1217 ST. PAUL ST

24a. REC'D BY REGISTRAR DATE: AUG 25 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9146

CERTIFICATE OF DEATH

09132
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Paradise Road

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: / Paradise Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Betty — Middle Trout — Last Motsinger

4. DATE OF DEATH: Month August — Day 21 — Year 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4 Oct. 1869

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Jacob Miller Trout

14. MOTHER'S MAIDEN NAME: Mary Magdalene Etzler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: ** **

17. INFORMANT: A.V. Motsinger — Address: Paradise Rd. Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Generalized Circulatory failure	Termina
DUE TO (b)	Pneumonia, hypostatic, rt. lung	1 wk
DUE TO (c)	Generalized arteriosclerosis	2 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] 1951, 19__ to 8-21-, 1958, that I last saw the deceased alive on 8/20/58, 1958, and that death occurred at 6:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): 8 Law Street

DATE SIGNED: 8-22-58

PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D. — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 8/23/58

22c. NAME OF CEMETERY OR CREMATORY: Mitchell Cemetery

22d LOCATION (City, town, or county) (State): Mitchell, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
John G. Tarring

ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: AUG 26 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9123

09133

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: Lifetime
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 109 N. Union
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Birlie — Middle: May — Last: Myers

4 DATE OF DEATH: Month: 8 — Day: 12 — Year: 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 19 1888

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife

10b KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Cambridge, Md.

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Levin Walter Robinson

14. MOTHER'S MAIDEN NAME: Alice Barwick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Unknown

17 INFORMANT: Walter Robinson — Address: 109 N. Union Ave Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Hemorrhage

DUE TO (b): Arterio Sclerosis

DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33i X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-20 19 56 to 19 56 that I last saw the deceased alive on 8/10 19 58 and that death occurred at 8 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED: 8-15-58

PHYSICIAN'S NAME (Type): A. H. Travis — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/15/58

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pumphrey & Son, Havre de Grace, Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE: AUG 19 '58

24b. REGISTRAR'S SIGNATURE: Clifford L. Preston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the [illegible] or attending physician.

TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director. [illegible] use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached [illegible] the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09134

9124

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Do not use this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 18 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Webster St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anne — Middle: Fredricka — Last: Noonan

4. DATE OF DEATH: Month: August — Day: 29 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 9, 1906

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Elementary Schools

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME: Fred Morlok

14. MOTHER'S MAIDEN NAME: Rosa De Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-38-2520

17. INFORMANT — Address: Mrs. Rosa Morlok, Aberdeen, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DIFFUSE PERITONITIS
DUE TO (b): RUPTURE DIVERTICULUM SIGMOID COLON
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____ that I last saw the deceased alive on August 29, 1958, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank D. Hauber. M.D. — ADDRESS (Street, city or town, state): 608 So. Union Ave. Havre de Grace, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Frank D. Hauber — 608 So., Union Ave., Havre de Grace, Md.,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 1, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. Paul's Lutheran

22d. LOCATION (City, town, or county) (State): Aberdeen R.D., Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McCormick Jr. — ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 3 '58

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09135

9125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 17½ DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 329 Wilson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: Ethel Last: POWELL

4. DATE OF DEATH: Month: August Day: 2 Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 1, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANDREW JACKSON LANDRUM

14. MOTHER'S MAIDEN NAME: ANNA MARIAH TISDALE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary Ethel Graham, Havre de Grace, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 7/15/58
4432
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Chr. Hypertensive Cardio-Vasc. Disease?
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1958, to Aug 2, 1958, that I last saw the deceased alive on Aug 1st, 1958, and that death occurred at 4:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson — ADDRESS (Street, city or town, state): Forest Hill, Md — DATE SIGNED: 8/2/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-4-1958

22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL

22d LOCATION (City, town or county) (State): HAVRE DE GRACE MD.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. Marion Mitchell Havre de Grace MD.

24a. REC'D BY REGISTRAR DATE: AUG 5 '58

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09136

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9147 Item 7 Film 233 8-29-58 et

Reg. Dist No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~PARADISE~~ R.D. #2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grover — Middle: C. — Last: Preston

4. DATE OF DEATH: Month: August — Day: 20 — Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 28 1885

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw-Mill Operator

10b. KIND OF BUSINESS OR INDUSTRY: Saw-Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Benjamin V. Preston

14. MOTHER'S MAIDEN NAME: Julia Lay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 213-12-4085

17. INFORMANT: Mrs. Grover C. Preston — Address: R.D. #2 Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D

EXAMINER'S NAME (Type): Gerald C Palmer M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Bel Air Md. — DATE SIGNED: 8-21-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/24/58

22c. NAME OF CEMETERY OR CREMATORY: Rock Run Cemetery

22d. LOCATION (City, town, or county) (State): RD. Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Fanning

ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kiland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de oy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9126 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROCKS SPRING (No. MAIN ST

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS: 1 No. MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle ELLEN Last SHANAHAN

4. DATE OF DEATH: Month AUGUST Day 2 Year 19 58

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 7, 1885
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeper
11. BIRTHPLACE (State or foreign country): Rocks, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Murphy
14. MOTHER'S MAIDEN NAME: Deborah Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Cornelia L. Murphy Address: 42 Maryland Ave Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: UNDER 1 HR

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ARTERIOSCLEROTIC HYPERTENSIVE — OVER 10 YRS

DUE TO

(c) CARDIO-VASCULAR DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: AUGUST 2, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: August 5, 1958
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air, Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster ADDRESS: Broadway + Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 5 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and ... to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9148

CERTIFICATE OF DEATH

09138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa (Rural)

c. LENGTH OF STAY IN 1b: 1 week

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown (Rural)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mountain Road

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First Georgia Middle Edith Last Shinault

4. DATE OF DEATH: August Month 20 Day 1958 Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒X

8. DATE OF BIRTH: March 15, 1905

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing Assistant

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Government

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Franklin Cornett

14. MOTHER'S MAIDEN NAME: Orlena ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: Mrs. Ruby Privett, Box 439 R.D.1 Mountain Rd. Joppa, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCT — INTERVAL BETWEEN ONSET AND DEATH: 6 WEEKS

420.1

DUE TO (b): CORONARY OCCLUSION — 11

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7-2, 1958 to 8-20, 1958, that I last saw the deceased alive on 8/4, 1958, and that death occurred at 3:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D Hirsch M.D — ADDRESS (Street, city or town, state): 421 CONGRESS AVE — DATE SIGNED

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — HAVRE DE GRACE, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-24, 1958

22c. NAME OF CEMETERY OR CREMATORY: Principio Methodist Cem.

22d. LOCATION (City, town, or county) (State): Principio, Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 25 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Russ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09139

9127

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

M

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Smothers

4. DATE OF DEATH: Month: August — Day: 16 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 17, 1934

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles E. Smothers

14. MOTHER'S MAIDEN NAME: Mary Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Charles E. Smothers — Address: Richardsville Road Bel-Air Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage from Left Pulmonary Vein
982X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Puncture pericardium

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Stabbed in fight

20c. TIME OF INJURY: Hour 10 a.m. p.m. — Month, Day, Year: 8-15 1958

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) Bel Air (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — Bel Air Md — DATE SIGNED: 8-16-58

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 20, 1958

22c. NAME OF CEMETERY OR CREMATORY: Clarks Chapel Cem.

22d. LOCATION (City, town, or county): Kalmia (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J Bullock — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR: DATE AUG 20 '58

24b. REGISTRAR'S SIGNATURE: Curtis L Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09140
Reg. Dist. No.

1 FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Monkton
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wilmer Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1210 Madison Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: J. — Last: Southerland
4. DATE OF DEATH: Month: Aug — Day: 23 — Year: 1958
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1905
9. AGE (Last birthday): 53 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Penna R.R.
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Southerland
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Winifred Southerland — Address: 1013 W. Fairvale Ave [redacted]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GSW Cerebrum — INTERVAL BETWEEN ONSET AND DEATH
919.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Ground hog hunting, rifle discharged accidentally
20c. TIME OF INJURY: Hour: 10 a.m. — Month, Day, Year: 8-23 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Wilmer farm
20f. (City or town): Monkton — (County): Harford — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D
EXAMINER'S NAME (Type): Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-23-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-26-58
22c. NAME OF CEMETERY OR CREMATORY: Fruit Culum
22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. W. Nelson — ADDRESS: 348 N. Calhoun St
24a. REC'D BY REGISTRAR DATE: AUG 26 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

20b: From Med. Exam.'s Office 10/15/58
A.S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9128

CERTIFICATE OF DEATH

09141
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 40 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 901 Erie St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Karen Middle: Frederica Last: Stinson

4. DATE OF DEATH: Month: Aug. Day: 30 Year: 1958

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 28, 1958

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours: 16 — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Mc Kinley Stinson

14. MOTHER'S MAIDEN NAME: Anna Jean Buchanon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracranial Hemorrhage

760.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 28, 1958, to Aug. 30, 1958, that I last saw the deceased alive on Aug. 30, 1958, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution St., Havre de Grace, Md. — DATE SIGNED: 8/30/58

PHYSICIAN'S NAME (Type): George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-31-58

22c. NAME OF CEMETERY OR CREMATORY: St. James Cemetery

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Otelia J. Bullock, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: SEP 3 '58

24b. REGISTRAR'S SIGNATURE: Irving S. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09142

9129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Hill
d. STREET ADDRESS: Rock Spring Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Janice — Middle: Allegra — Last: Terrell

4. DATE OF DEATH: Month: August — Day: 7 — Year: 1958

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1958

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days: 14 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Henry Presbury

14. MOTHER'S MAIDEN NAME: Helen Terrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17. INFORMANT: Helen Terrell — Address: Rock Spring Rd, Forest Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Bilateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dehydration

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 6, 1958, to Aug. 7, 1958, that I last saw the deceased alive on Aug. 7, 1958, and that death occurred at 6:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Erlinda L. Marbella, M.D. — ADDRESS (Street, city or town, state): 413 Revolution St. Havre de Grace, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): ERLINDA L. MARBELLA, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 8, 1958

22c. NAME OF CEMETERY OR CREMATORY: St. James A.M.E. Cem.

22d LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock — ADDRESS: 556 Lewis St. Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '58

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9130 — Reg. Dist. No. — 09143

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Aberdeen
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
d. STREET ADDRESS: R.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nina — Middle Bell — Last Vesely
4. DATE OF DEATH: Month August — Day 16 — Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 28 Feb. 1904
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Homer
14. MOTHER'S MAIDEN NAME: Ida Bell Singleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Joseph W. Vesely — Address R.D. #1 Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident.
DUE TO (b): Cirrhosis of The Liver — INTERVAL BETWEEN ONSET AND DEATH: 24 Month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 15, 1958, to August 16 1958, that I last saw the deceased alive on Aug. 16 —, 1958, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D.
ADDRESS (Street, city or town, state): 17 N. Phila. Blvd.
DATE SIGNED: 8/18/58

PHYSICIAN'S NAME (Type): Andre Weiss M.D. — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/19/58
22c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
22d. LOCATION (City, town, or county) (State): R.D., Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John T. Barrug
ADDRESS: Aberdeen, Md.
24a. RECEIVED BY REGISTRAR DATE: AUG 21 58
24b. REGISTRAR'S SIGNATURE: Clifton L. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09144

9131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 6 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
d. STREET ADDRESS: R.D#1, Box 224
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Emory — Last: Walbeck
4. DATE OF DEATH: Month: 8 — Day: 31 — Year: 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Herman Walbeck
14. MOTHER'S MAIDEN NAME: Catherine Greenwald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Calvin Walbeck North East R.D. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: approx. 6 mon.
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ca. of Prostate
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/24/58 to 8/31/58 that I last saw the deceased alive on 8/31/58, and that death occurred at 8:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Loo M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave. — DATE SIGNED: 8/31/58

PHYSICIAN'S NAME (Type): Edward C. Loo, M.D., Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 3 1958
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): North East Cecil Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East Md

24a. REC'D BY REGISTRAR DATE: SEP 3 '58
24b. REGISTRAR'S SIGNATURE: Calvin S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director. [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9132 **CERTIFICATE OF DEATH** Reg. Dist. No. 09145

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air
d. STREET ADDRESS 625 Roland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Louis Middle Joseph Last Waldenberger
4. DATE OF DEATH Month August Day 4 Year 1958

5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/23/06
9. AGE (In years last Birthday) 51 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County Engineer
10b. KIND OF BUSINESS OR INDUSTRY Highway Construction
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U-S-A.

13. FATHER'S NAME Louis Joseph Waldenberger
14. MOTHER'S MAIDEN NAME Alice McKethrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO. 212-10-7513
17. INFORMANT Address Frances Waldenberger - Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH 2 days.
DUE TO (b) Cardiac Decompensation — about 1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c) Arteriosclerotic Cardiovascular Disease — 3-4 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cholelithiasis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 28th, 1958, to Aug. 4th, 1958, that I last saw the deceased alive on Aug. 4th, 1958, and that death occurred at 4:10 A.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Edward C. Loo M.D. ADDRESS (Street, city or town, state) 211 N. Union Ave. DATE SIGNED Aug. 4th, 1958
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF August 6, 1958
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State) Bel Air, Harford County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway and Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE AUG 5 '58
24b. REGISTRAR'S SIGNATURE Alice Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9133

CERTIFICATE OF DEATH

09146

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 2 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN RURAL
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: B — Last: WALL

4. DATE OF DEATH: Month: August — Day: 26 — Year: 1958

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/2/1898

9. AGE (If years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembler A.P.G.

10b. KIND OF BUSINESS OR INDUSTRY: Govt.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MACK WALL

14. MOTHER'S MAIDEN NAME: Floy Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War # 1

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mrs Robt. B Wall — Address: aberdeen # 1-Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hr.
DUE TO (b): Arterial Hypertension ("Essential") — 5 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Asthma; Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__, to 8-26-1958 that I last saw the deceased alive on 8/26/58, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D. — ADDRESS (Street, city or town, state): 8 Law St., Aberdeen, Md. — DATE SIGNED: 8/26/58

PHYSICIAN'S NAME (Type): Peter P. Rodman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/28/1958

22c. NAME OF CEMETERY OR CREMATORY: Oak Grove Baptist

22d. LOCATION (City, town, or county) (State): Bel Air R.F.D. Md.

23. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: John G. Garrity Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: AUG 28 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09147

9150

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 30 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Aberdeen Proving Ground, Md

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 1 Rigdon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle Joseph — Last Walsh

4. DATE OF DEATH: Month August — Day 27 — Year 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9 Jan 1879

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Army M Sgt

10b. KIND OF BUSINESS OR INDUSTRY: Army

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY: United States

13. FATHER'S NAME: Patrick Walsh

14. MOTHER'S MAIDEN NAME: Mary (Unknown) Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mrs Mary Walsh (wife)
Address: 1 Rigdon Road Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured Abdominal Aneurysm (Aorta) — INTERVAL BETWEEN ONSET AND DEATH

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Arteriosclerosis, Aorta

DUE TO (c): Arteriosclerosis, General

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 27 19 58 to August 27 19 58 that I last saw the deceased alive on August 27 19 58, and that death occurred at 6:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph N. Silverstein M.D.
ADDRESS (Street, city or town, state): US Army Hospital Aberdeen PG Md
DATE SIGNED: 27 Aug 58

PHYSICIAN'S NAME (Type): JOSEPH N SILVERSTEIN Capt MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/1958
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Harvey
ADDRESS: Aberdeen md

24a. REC'D BY REGISTRAR DATE: SEP 2 '58
24b. REGISTRAR'S SIGNATURE: C. M. S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09148

CERTIFICATE OF DEATH

9151 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Street

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Street

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Frank Middle: Smith Last: Webb

4. DATE OF DEATH: Month: Aug. Day: 13, Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 17, 1871

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): York Co., Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H. Webb

14. MOTHER'S MAIDEN NAME: Salome M. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs. Mary Webb, Street Rd., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Instant

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteria Sclerotic C-V Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 58, to Aug 13, 58, that I last saw the deceased alive on Aug 5, 58, and that death occurred at 9:22 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Josiah A. Hunt M.D. ADDRESS (Street, city or town, state): Delta, Pa DATE SIGNED: 8/14/58

PHYSICIAN'S NAME (Type): Josiah A. Hunt 1912

22a. BURIAL, CREMATION, (Specify): Burial 22b. DATE THEREOF: 8-16-58 22c. NAME OF CEMETERY OR CREMATORY: Fawn Grove Meth. 22d. LOCATION (City, town, or county) (State): Fawn Grove, York Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth W. Cashman ADDRESS: Stewartstown, Pa.

24a. REC'D BY REGISTRAR DATE: AUG 18 '58 24b. REGISTRAR'S SIGNATURE: Carlton E. Hawk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9134

CERTIFICATE OF DEATH

Reg. Dist. No. 09149

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 30 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 130 Wilson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gregg — Middle: — Last: Williams

4. DATE OF DEATH: Month: August — Day: 5 — Year: 19 58

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 4 1958

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roger E. Williams

14. MOTHER'S MAIDEN NAME: Naomi Arlene Schaffhauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cyanotic congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

754.5

DUE TO (b): Miliary atelectasis — 30 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/5, 19 58, to 8/5, 19 58, that I last saw the deceased alive on 8/5, 19 58, and that death occurred at 10:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Cavier M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/6/58

22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel

22d. LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Reynolds Funeral Home — ADDRESS: Havre de Grace

24a. REC'D BY REGISTRAR DATE: AUG 8 '58

24b. REGISTRAR'S SIGNATURE: Alice Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

2071385 XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09150

9135

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN 1b: 30 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Havre de Grace
d. STREET ADDRESS: Rock Run Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jane W. — Last: Willis
4. DATE OF DEATH: Month: August — Day: 18 — Year: 19 58

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: April 28, 1953 — 9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None — 10b. KIND OF BUSINESS OR INDUSTRY: None — 11. BIRTHPLACE (State or foreign country): Harford Co, Md. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank M. Willis — 14. MOTHER'S MAIDEN NAME: Viola Catron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: No — 17. INFORMANT: Mrs. Viola Willis — Address: Havre de Grace Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Cervicle entered — DUE TO: 810 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — (b) DUE TO — (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture R femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto-train type

20c. TIME OF INJURY: Hour: 11:50 a.m. — Month, Day, Year: 8-18 1958 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Penn RR — 20f. (City or town): Aberdeen (County): Harford (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Donald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md — DATE SIGNED: 8-18-58
EXAMINER'S NAME (Type): Donald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: Aug. 21, 1958 — 22c. NAME OF CEMETERY OR CREMATORY: Babtist View — 22d. LOCATION (City, town, or county): Harford Co. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR DATE: AUG 25 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss